# Imperial Health Holdings Medical Group

## Provider Reference Manual 2017

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SECTION 1. INTRODUCTION

1.1 Imperial Health Holdings Medical Group (IHHMG)

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP (IHHMG)

Imperial Health Holdings Medical Group (IHHMG) is a health care service plan with a select network of providers based in Los Angeles County, Riverside County, San Bernardino County, San Diego County, Orange County, Kern County, Fresno County, Santa Clara County, and Alameda County with Hospital Coverage that will serve populations with Medicare Advantage or Dual Eligible Coverage.

The IHHMG is overseen by an executive board, a Medical Director, a Quality Management Committee, and a Public Policy Committee

1.2 Quality Management Committee

The Quality Management Committee is core to our business, and is responsible for Utilization Management (UM) and Quality Management (QM) functions. Utilization Management staff is familiar with pre-authorization processes required by each health plan contracted IHHMG. Our goal is to expedite referral requests from providers and approve them in one or two working days. Other Utilization Management functions include:

- Implementation of UM Program and Work Plan
- UM Reporting required by health plans
- Preparation for and Participation in UM Audits conducted by health plans
- Hospital Case Management
- California Children's Services (CCS) Case Management
- After-hours triage
- Other services as required by contracted health plans and regulatory agencies.

Quality Management staff monitors the quality of care provided by IHHMG providers and conducts quality assessment studies. Quality Management functions include:

- Implementation of Quality Management Program and Work Plan
- Practice pattern profiling and analysis
- Quality management studies and reports required by health plans
- Preparation for and Participation in QM Audits conducted by health plans
- Member complaints and grievances resolution
- Clinical provider complaints and grievances
- Credentialing and re-credentialing process
- Other services as required by contracted health plans and regulatory agencies

1.3 Provider Relations and Network Operations

Provider Relations (PR) is committed to being accessible to all contracted physicians on a daily basis. The representatives are responsible for answering inquiries and concerns from contracted providers and assist with resolution.

Provider Relations shall work with contracted providers to ensure that the provider has the necessary information, resources, and assistance to work with the IPA. The following are the responsibilities for Provider Relations:

- Provider Orientation to cover operations for Customer Service, Utilization Management, Claims, Eligibility, IPA rosters, and Quality Management.
- Provider Manual Distribution
- Issues Resolution involving authorizations, claims, eligibility, capitation, contracting
- Provider Education/Training
- Network Updates
- IPA or Health Plan Policy Changes/Updates
• Health Education Material Distribution
• Member Enrollment Issues
• Provider Complaints
• Assistance with Grievances

Provider Relations Department is available Monday-Friday from 9:00 a.m. – 5:00 p.m. Our contact information is follows:

• By phone: (626) 838-5100 Option 4  • By email: PNO@imperialhealthholdings.com

1.4 Credentialing
This Department maintains Provider credentialing file in compliance with standards recognized and mandated by NCQA, contracted health plans and other accrediting agencies.

1.5 Enrollment and Eligibility
This Department processes eligibility lists (electronic or paper) from health plans, prepares and mails eligibility lists to Primary Care Providers, administers and reconciles eligibility.

1.6 Claims and Encounter Data Processing
The Claims and Encounter Data Department adjudicates, reviews, pays and analyzes claims, compiles claims timeliness reporting, participates in claims audits by health plans, and processes encounter data and report to health plans.
SECTION 2. IMPORTANT CONTACT NUMBERS

2.1 Imperial Health Holdings Medical Group Contact Numbers
Please refer to attached “Contact List.”

2.2 Health Plan Contact Numbers

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>LOB</th>
<th>Member Services Contact Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment HP</td>
<td>Medicare</td>
<td>(866) 634-2247</td>
<td><a href="http://www.alignmenthealthplan.com">www.alignmenthealthplan.com</a></td>
</tr>
<tr>
<td>Blue Cross</td>
<td>Medical</td>
<td>(800) 407-4627</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
</tr>
<tr>
<td>Brand New Day HP</td>
<td>Medicare</td>
<td>(866) 255-4795</td>
<td><a href="http://brandnewdayhmo.com/">http://brandnewdayhmo.com/</a></td>
</tr>
<tr>
<td>Care1st HP</td>
<td>Medicare</td>
<td>(800) 544-0088</td>
<td><a href="http://www.care1st.com">www.care1st.com</a></td>
</tr>
<tr>
<td>Care1st HP</td>
<td>Medical</td>
<td>(800) 605-2556</td>
<td><a href="http://www.care1st.com">www.care1st.com</a></td>
</tr>
<tr>
<td>CCHP</td>
<td>Medicare</td>
<td>(880) 775-7888</td>
<td><a href="http://www.cchphealthplan.com">www.cchphealthplan.com</a></td>
</tr>
<tr>
<td>Central HP</td>
<td>Medicare</td>
<td>(866) 314-2427</td>
<td><a href="http://www.centralhealthplan.com">www.centralhealthplan.com</a></td>
</tr>
<tr>
<td>Easy Choice HP</td>
<td>Medicare</td>
<td>(866) 999-3945</td>
<td><a href="http://www.easychoicehealthplan.com">www.easychoicehealthplan.com</a></td>
</tr>
<tr>
<td>Humana HP</td>
<td>Medicare</td>
<td>(800) 457-4708</td>
<td><a href="http://www.humana.com">www.humana.com</a></td>
</tr>
</tbody>
</table>

Easy Choice online eligibility verification:
https://secure2.ehcsmc.net/ECHP.NET/RemoteMemberEligVerification.aspx

2.3 Other Contact Numbers
Primary Care Providers may also contact the following organizations for additional information.

Centers for Medicare and Medicaid Services: For verification of eligibility for Medicare patients and managed care members, call the toll free line at: (800) MEDICARE or (800) 633-4227.

State Department of Health Services: For verification of eligibility for Medicaid patients and managed care members, call the Automated Eligibility Verification Services (AEVS) at (800) 456 2387. A Provider number is required to obtain eligibility information. For claims issues, contact: EDS at (800) 541-5555.
SECTION 3. RESPONSIBILITIES OF IHP PHYSICIANS

3.1 Medical Services Covered under Primary Care Capitation

The following services are covered under the monthly capitation paid to contracted Primary Care Physicians (PCPs) unless special arrangements have been made with IPA. Please refer to your Primary Care Provider Agreement with IPA for more details regarding coverage provisions. Covered Medical Services include all of the services a PCP customarily makes available to patients of his or her practice, including but not limited to the services listed below:

- Maintain office accessibility to members at least 4.5 days per week. All PCPs are required to provide and arrange for 24 hour, 7 days per week on-call coverage for all managed care members unless previous arrangements have been made with IPA
- First point of contact care for persons with previously undifferentiated health concerns
- Office Visits and Examinations (diagnosis treatment of illness and injury);
- Adult health maintenance
- Periodic health appraisal examination, including all routine tests performed in PCP’s office
- Routine gynecological examinations including pap smears
- Venipuncture and administration of injections and injectables
- Minor office surgical procedures, including repair of simple lacerations to areas other than the face, ear lavage, I&D of superficial soft tissue abscess, EKG, visual acuity testing, trigger point injections, arthrocentesis, etc.
- Specimen collection
- Nutritional counseling
- Interpretation of laboratory results
- Miscellaneous supplies related to treatment in PCP’s Office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies)
- Telephone consultations
- Well-Child Care, including screening and testing for vision and hearing;
- Coordination of other health care services as they relate to a Plan Member’s care
- Immunizations, for adults and children, in accordance with accepted medical practice in the community; and
- Health education in disease prevention, exercise, and healthy living practices

The following listed services are generally considered primary care services. The PCP must have received appropriate training, within the limitations of scope of practice, and consistent with State and Federal rules and regulations. These guidelines are based on routine uncomplicated cases where care is ordinarily provided by a PCP. This list only provides guidelines, is not intended to be all inclusive, and should be used with clinical discretion.

<table>
<thead>
<tr>
<th>Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Treat seasonal allergies</td>
</tr>
<tr>
<td>• Treat hives</td>
</tr>
<tr>
<td>• Treat chronic rhinitis</td>
</tr>
<tr>
<td>• Allergy history</td>
</tr>
<tr>
<td>• Environmental counseling</td>
</tr>
</tbody>
</table>

| • Minor insect bites/stings |
| • Asthma, active with or without co-existing infection |
| • Allergy testing and institute immunotherapy - if appropriately trained |
| • Administer immunotherapy |

<table>
<thead>
<tr>
<th>Adult Cardiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Perform electrocardiograms</td>
</tr>
<tr>
<td>• Interpret electrocardiograms</td>
</tr>
<tr>
<td>• Evaluate chest pain</td>
</tr>
<tr>
<td>• Evaluate and treat coronary risk factors, including smoking, hyperlipidemias, diabetes, hypertension</td>
</tr>
</tbody>
</table>

<p>| • Evaluate and treat uncomplicated hypertension, CHF, stable angina, non life-threatening arrhythmias |
| • Evaluate single episode syncope (cardiac) |
| • Evaluate benign murmurs and palpitations |</p>
<table>
<thead>
<tr>
<th>Dermatology</th>
<th>Endocrinology</th>
<th>Gastroenterology</th>
<th>General Surgery</th>
<th>Geriatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Treat acne - acute and recurrent</td>
<td>• Diabetic management, including Type I and Type II for most patients</td>
<td>• Diagnose and treat lower abdominal pain</td>
<td>• Evaluate and follow small breast lumps in teenagers</td>
<td>• Diagnose and treat impaired cognition (dementia)</td>
</tr>
<tr>
<td>• Treat painful or disabling warts with topical suspensions, electrocautery, liquid nitrogen</td>
<td>• Patient education</td>
<td>• Diagnose and treat acute diarrhea</td>
<td>• Order screening mammograms</td>
<td>• Be familiar with effects of aging on drug distribution, drug metabolism, and drug-drug interaction</td>
</tr>
<tr>
<td>• Diagnose and treat common rashes including: contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor</td>
<td>• Supervision of home (SBGM) testing</td>
<td>• Perform flexible sigmoidoscopy</td>
<td>• Aspirate cysts</td>
<td>• Management of advanced illness including the use of alternative levels of care</td>
</tr>
<tr>
<td>• Screen for basal or squamous cell carcinomas</td>
<td>• Medication management</td>
<td>• Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease</td>
<td>• Foreign body removal</td>
<td>• Recognition of elder abuse</td>
</tr>
<tr>
<td>• Biopsy suspicious lesions, if trained may do biopsy of suspicious lesions for cancer or others such as actinic keratoses</td>
<td>• Manage DKA</td>
<td>• Evaluate acute abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Punch biopsy</td>
<td>• Manage thyroid nodules (testing, scans, ultrasound)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incisional biopsy</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- **Dermatology**
  - Treat acne - acute and recurrent
  - Treat painful or disabling warts with topical suspensions, electrocautery, liquid nitrogen
  - Diagnose and treat common rashes including: contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor
  - Screen for basal or squamous cell carcinomas
  - Biopsy suspicious lesions, if trained may do biopsy of suspicious lesions for cancer or others such as actinic keratoses
  - Punch biopsy
  - Incisional biopsy

- **Endocrinology**
  - Diabetic management, including Type I and Type II for most patients
  - Patient education
  - Supervision of home (SBGM) testing
  - Medication management
  - Manage DKA
  - Manage thyroid nodules (testing, scans, ultrasound)

- **Gastroenterology**
  - Diagnose and treat lower abdominal pain
  - Diagnose and treat acute diarrhea
  - Perform flexible sigmoidoscopy
  - Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease
  - Evaluate acute abdominal pain

- **General Surgery**
  - Evaluate and follow small breast lumps in teenagers
  - Order screening mammograms
  - Aspirate cysts
  - Foreign body removal

- **Geriatrics**
  - Diagnose and treat impaired cognition (dementia)
  - Be familiar with effects of aging on drug distribution, drug metabolism, and drug-drug interaction

- **Endocrinology**
  - Diagnose and treat thyroid disorders
  - Identify and treat hyperlipidemia
  - Diet instruction
  - Exercise instruction
  - Provide patient education for osteoporosis risk factors

- **Gastroenterology**
  - Diagnose and treat uncomplicated inflammatory bowel disease
  - Diagnose jaundice
  - Diagnose and treat ascites
  - Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids
  - Manage functional bowel disease
  - Manage diagnosed malabsorption syndrome
  - Manage mild hepatitis A

- **Geriatrics**
  - Management of advanced illness including the use of alternative levels of care
  - Recognition of elder abuse
<table>
<thead>
<tr>
<th><strong>Gynecology / OB</strong></th>
<th><strong>Neurology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Perform routine pelvic exams and PAP smears</td>
<td>• Diagnose and treat lower abdominal pain to distinguish gynecological from gastrointestinal causes</td>
</tr>
<tr>
<td>• Perform lab testing for sexually transmitted diseases</td>
<td>• Diagnose irregular vaginal bleeding</td>
</tr>
<tr>
<td>• Wet mounts</td>
<td>• Diagnose and treat endometriosis with hormone therapy</td>
</tr>
<tr>
<td>• Diagnose and treat vaginitis and sexually transmitted diseases</td>
<td>• Manage premenstrual syndrome with non-steroidal anti-inflammatory hormones and symptomatic treatment</td>
</tr>
<tr>
<td>• Contraceptive counseling and management</td>
<td>• Wet mounts</td>
</tr>
<tr>
<td>• Normal pregnancy (if physician privileged to deliver)</td>
<td>• Diagnose and management of syncope</td>
</tr>
</tbody>
</table>

**Neurology**

<table>
<thead>
<tr>
<th><strong>Ophthalmology</strong></th>
<th><strong>Orthopedics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnose and treat all psychophysiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, radiculopathies, and central nervous system disorders</td>
<td>• Treat low back pain and sciatica without neurological deficit</td>
</tr>
<tr>
<td>• Diagnose and treat tension and migraine headaches</td>
<td>• Treat sprains, strains, pulled muscles, overuse symptoms</td>
</tr>
<tr>
<td>• Order advanced imaging procedures (MRI or CT scan at an appropriate anatomic level after an appropriate clinical evaluation and trial of conservative therapy)</td>
<td>• Treat acute inflammatory conditions</td>
</tr>
<tr>
<td></td>
<td>• Chronic knee problems</td>
</tr>
<tr>
<td></td>
<td>• Manage chronic pain problems</td>
</tr>
</tbody>
</table>

**Ophthalmology**

<table>
<thead>
<tr>
<th><strong>Orthopedics</strong></th>
<th><strong>Otolaryngology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Diagnose and treat common foot problems: ingrown nails, corns/callosoles, bunions</td>
</tr>
<tr>
<td>• Perform thorough ophthalmologic history including symptoms and subjective visual acuity</td>
<td>• Closed emergency reduction of dislocation: digit, patella, shoulder</td>
</tr>
<tr>
<td>&gt; Distant/near testing</td>
<td>• Treatment of minor fractures</td>
</tr>
<tr>
<td>&gt; Color vision testing</td>
<td>• Arthrocentesis</td>
</tr>
<tr>
<td>&gt; Gross visual field testing by confrontation</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Medicine and Rehabilitation</strong></td>
<td><strong>Psychiatry(*)</strong></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>• Coordinate care for patients recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist</td>
<td>• Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA, AFO for foot drop</td>
</tr>
<tr>
<td>• Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns and acquired sexual problems)</td>
<td>• Diagnose physical disorders with behavioral manifestation</td>
</tr>
<tr>
<td></td>
<td>• Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist</td>
</tr>
<tr>
<td></td>
<td>• Diagnose and manage child, elder, dependent adult abuse, and domestic violence victims</td>
</tr>
</tbody>
</table>

(*) Only for Medi-Cal Managed Care, this is a “carve-out” service and PCP is only responsible for H&P for patients/members before inpatient mental health admissions and for assessment and referral to County Mental Health Department for outpatient mental health services.

(*) For some Medicare Advantage/Medi-Medi HMOs, this is a “carve-out” service and PCP should refer to these HMOs for Mental Health Network for all services.
<table>
<thead>
<tr>
<th>Pulmonology</th>
<th>Rheumatology</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnose and treat asthma, acute bronchitis, pneumonia</td>
<td>• Diagnose and treat non-articular musculoskeletal problems:</td>
</tr>
<tr>
<td>• Diagnose and treat chronic bronchitis</td>
<td>&gt; Overuse syndromes</td>
</tr>
<tr>
<td>• Diagnose and treat chronic obstructive pulmonary disease</td>
<td>&gt; Injuries and trauma</td>
</tr>
<tr>
<td>• Manage home aerosol medications and oxygen</td>
<td>&gt; Soft tissue syndromes</td>
</tr>
<tr>
<td>• Work up possible tuberculosis or fungal infections</td>
<td>&gt; Bursitis or tendonitis</td>
</tr>
<tr>
<td>• Treat opportunistic infection</td>
<td>• Diagnose crystal diseases</td>
</tr>
<tr>
<td>• Order chest x-rays, special views and CT scans</td>
<td>• Perform arthrocentesis</td>
</tr>
<tr>
<td>• Diagnose and treat chronic obstructive pulmonary disease</td>
<td>• Diagnose and treat rheumatoid arthritis</td>
</tr>
<tr>
<td>• Provide steroid injections</td>
<td>• Diagnose and treat inflammatory arthritic diseases</td>
</tr>
<tr>
<td>• Manage osteoarthritis unless there is a significant functional impairment</td>
<td>• Diagnose and treat uncomplicated collagen diseases</td>
</tr>
<tr>
<td>based on treatment</td>
<td></td>
</tr>
<tr>
<td>• Evaluate hematospermia</td>
<td></td>
</tr>
<tr>
<td>• Initiate evaluation of hematuria</td>
<td></td>
</tr>
<tr>
<td>• Evaluate incontinence</td>
<td></td>
</tr>
<tr>
<td>• Evaluate male factor infertility and impotence and treat readily correctable factors</td>
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<tr>
<td>• Diagnose and treat epididymitis and prostatitis</td>
<td></td>
</tr>
<tr>
<td>• Differentiate scrotal or peritesticular masses from testicular masses</td>
<td></td>
</tr>
<tr>
<td>• Evaluate prostatism and prostatic nodules</td>
<td></td>
</tr>
<tr>
<td>• Manage urinary stones</td>
<td></td>
</tr>
<tr>
<td>• Evaluate and treat renal failure</td>
<td></td>
</tr>
<tr>
<td>• Placement of urinary catheters</td>
<td></td>
</tr>
<tr>
<td>• Evaluate impotence</td>
<td></td>
</tr>
<tr>
<td>• Evaluate male infertility</td>
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<table>
<thead>
<tr>
<th>Urology / Nephrology</th>
<th>Vascular Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnose and treat initial and recurrent urinary tract infections</td>
<td>• Diagnose abdominal aortic aneurysm</td>
</tr>
<tr>
<td>• Provide long term chemoprophylaxis</td>
<td>• Manage intermittent claudication</td>
</tr>
<tr>
<td>• Diagnose and treat urethritis</td>
<td>• Manage transient ischemic attacks</td>
</tr>
<tr>
<td>• Explain hematospermia</td>
<td>• Manage asymptomatic bruits</td>
</tr>
<tr>
<td>• Initiate evaluation of hematuria</td>
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<tr>
<td>• Evaluate incontinence</td>
<td></td>
</tr>
<tr>
<td>• Evaluate male factor infertility and impotence and treat readily correctable factors</td>
<td></td>
</tr>
<tr>
<td>• Differentiate scrotal or peritesticular masses from testicular masses</td>
<td></td>
</tr>
<tr>
<td>• Evaluate prostatism and prostatic nodules</td>
<td></td>
</tr>
<tr>
<td>• Manage urinary stones</td>
<td></td>
</tr>
<tr>
<td>• Evaluate and treat renal failure</td>
<td></td>
</tr>
<tr>
<td>• Placement of urinary catheters</td>
<td></td>
</tr>
<tr>
<td>• Evaluate impotence</td>
<td></td>
</tr>
<tr>
<td>• Evaluate male infertility</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Vascular Surgery</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnose abdominal aortic aneurysm</td>
<td>• Basic life support</td>
</tr>
<tr>
<td>• Diagnose and treat venous diseases</td>
<td>• Advanced life support</td>
</tr>
<tr>
<td>• Treat stasis ulcers</td>
<td>• Heimlich maneuver</td>
</tr>
<tr>
<td>• Manage intermittent claudication</td>
<td>• Endotracheal intubation</td>
</tr>
<tr>
<td>• Manage transient ischemic attacks</td>
<td>• Tracheostomy (emergency)</td>
</tr>
<tr>
<td>• Manage asymptomatic bruits</td>
<td></td>
</tr>
</tbody>
</table>

3.2 Role of Specialty Care Physician

Specialty care physicians provide referral services consistent with industry standard medical practices, to IPA members upon request by the PCP with authorization from the IPA. The Specialist is responsible for communicating results and findings back to the member’s PCP for continuity and/or coordination of care. The Specialist is responsible for the following:

- Provide IPA authorized medically necessary specialty care
- Work in conjunction with PCP to assure continuity of patient care
- Specialist will make authorization requests through the referring PCP
- Submit treatment plans to PCP and IPA for continued specialty care
- Assist PCP/IPA in coordinating ancillary services and hospitalization
• Arrange for practice coverage by another IPA contracted/participating physician for times or extended periods Specialist is unavailable (i.e. vacation, jury duty, holidays, illness, etc.)
• Provide and arrange for 24 hour, 7 days per week on-call coverage for all managed care members
• Participate in respective UM/QM committees and programs as may be required under contract

NOTE:
Specialists can only submit referral authorization requests, through the PCP, for additional continued care or treatment of members and cannot refer members to other specialists. Unauthorized services will not be reimbursed.

IPA must be notified to arrange for a Memorandum of Understanding to be in place if a non-participating physician is scheduled to take calls for you or assist you with a service or procedure. USE OF A CALL ANSWERING MACHINE IS NOT AN ACCEPTABLE FORM OF ON-CALL COVERAGE.

3.3 Appointments and Services
The following are standards and requirements for appointments and services rendered by Primary Care Physicians as required by Health Plan, CMS and/or other regulatory agencies including the State Department of Health Services (SDHS) and the Department of Managed Health Care (DHMC)

<table>
<thead>
<tr>
<th>Type of Appointment and Services</th>
<th>Access Standards and Requirements</th>
</tr>
</thead>
</table>
| Availability of the PCP         | • PCP must be available by telephone 24-hours per day/ seven days per week.  
                                  | • If the PCP is unable to provide on-call services, arrangements must be in place to cover the PCP after hours and on weekends; covering physician must be credentialed by IPA |
| Appointment Systems             | • Providers should use an efficient and effective written or computerized appointment making system, which includes follow-up on broken appointment. |
| Waiting Time in the Office      | • The waiting time for scheduled appointments must be 30 minutes or less. |
| Appointments for Urgent and Routine Primary Care Services | • For urgent primary care services, PCPs are required to triage and provide same-day appointment for his/her members. 
  • For Routine primary care services, the timeline for appointments is as follows:  
    1. For physical exam and routine preventive services – 4 work weeks.  
    2. Routine ambulatory visits – 7 business days maximum for an appointment. |
<p>| Appointments for Routine Physician Consultation and Specialty Referral | • Specialist physicians are expected to schedule an appointment for a non-urgent, properly authorized referral within 10 business days. |</p>
<table>
<thead>
<tr>
<th>Type of Appointment and Services</th>
<th>Access Standards and Requirements</th>
</tr>
</thead>
</table>
| Appointment for Routine Prenatal Care | • Initial appointments must be available to members within one week from member request for members in their 1<sup>st</sup>/2<sup>nd</sup> trimester  
• Initial appointments must be made within 3 days of request for members in their 3<sup>rd</sup> trimester or identified as ‘high risk’. |
| 90 day Initial Health Assessment (IHA) | • Each newly enrolled MA member is expected to receive an IHA within 90 days of enrollment.  
• Use of the age-specific “Staying Healthy Assessment” tool is acceptable and must be completed at the time of the IHA |
| “Staying Healthy Assessment” | • For members currently enrolled with the PCP, the age-specific tool should be completed during routine physical exam or when a member enters another age group. |
| Appointment for Sensitive Services | • Sensitive services must be made available to members within two days from request for appointment.  
• Sensitive services are: Sexual assault, Drug or alcohol abuse, Pregnancy/Family Planning and sexually transmitted diseases  
• These services will be provided under the following conditions:  
1. Without necessity of preauthorization, referral, or parental consent for minors 12 years of age and older.  
2. Confidentially, in a manner that respects the privacy and dignity of the individual |

3.4 Telephone Access  
PCP or office staff must return any non-urgent phone calls within 24 hours to members. Urgent and emergent calls are to be handled by the primary care physician, immediately, 24 hours a day, 7 days a week unless other arrangements have been made with IPA.

3.5 Services for Members with Disabilities  
Primary and Specialty Care Physicians must comply with all the provisions of the Americans with Disabilities Act including: A handicapped bathroom or alternative access which is equipped with handrails in the bathroom, handicapped access ramp, handicapped water fountain or alternative provisions, an elevator, when applicable, and at least one handicapped parking space.

TDD/TTY Access for the Hearing Impaired  
California State TDD line is 1 (800) 735-2922 and is available to all California residents

3.6 Interpretive Services  
• Primary and Specialty Care Physicians are required to offer interpretive services to member in order to provide quality health care services  
• If a member declines the interpretive services, the provider must note this in the member’s medical records
IPA providers are expected to provide interpretive services 24 hours a day through their AT&T or other contracted language lines, which providers can access if requested by the member in his/her language.

If a patient has limited English and requires language assistance, contact the appropriate health plan at the number listed above.

3.7 Credentialing and Facility Site Review
IPA contracted providers are required to be credentialed in accordance with guidelines set forth in IPA’s Credentialing Policies and Procedures and as required by other applicable regulatory agencies or accrediting bodies. Acceptance of a provider into IPA is contingent upon successfully completing the credentialing process. Additionally, Primary Care Physicians participating in Medi Cal and/or Medicare/Medi-Medi managed care must pass facility site reviews conducted by oversight Plan. Continued participation with IPA is dependent upon successfully completing the re credentialing process that takes place every three (3) years.

The following documents are required for the initial credentialing process:
• Completed California Participating Physician Application
• Copy of current California Medical License
• Copy of current DEA Certificate
• Copy of current Liability Insurance Policy
• Curriculum Vitae
• Copy of Board Certificate (if applicable)
• Hospital Affiliation
• SNP Model of Training (Medicare SNP providers only)

In addition to the above, the following criteria are incorporated into the re credentialing process:
• Member complaints
• Information from quality improvement activities
• Member satisfaction

A. Provider Status Change
The State Department of Health Services and CMS mandates that members be notified of any provider status change 30 days prior to the change, or in cases of emergency, within 14 days of the change.

Any planned change in status such as an address or phone number change, malpractice insurance coverage or staffing changes, must be reported immediately to IHP (Refer to Provider Change Notification Form in the Forms Section of this Manual)

B. Required Reporting
IPA must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank within 15 calendar days after the effective date of the action, if any of the following events occurs:
• The provider's application for IPA participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.
• The provider's participation status is terminated or revoked for a medical disciplinary cause or reason.
• Restrictions are imposed or voluntarily accepted for a cumulative total of 30 days or more for any 12 month period, for a medical disciplinary cause or reason.
• The provider resigns or takes a leave of absence from IPA
• IPA participation status changes following notice of any impending investigation based on information indicating medical disciplinary cause or reason.

The provider must be notified in writing of any adverse action taken. A contracted physician may request a fair hearing if there has been a reduction, termination or suspension of the provider's contractual relationship.

3.8 Hospital Admissions and Admitting Staff
IPA Primary Care Physicians should have admitting privileges to at least one of the contracted hospitals. The Admitting Team should always be notified by the PCP for assistance and coordination of care whenever IPA member needs to be admitted. Refer to IHHMG and IPA Medical Director for notification and follow-up.

3.9 Initial Health Assessments (IHA)
The CMS Medicare Advantage requires an IHA to be performed on all assigned Medicare members within 90 to 120 days of the effective date of enrollment. The “Staying Healthy Assessment” tool can be utilized by PCPs as an IHA for Medicare Advantage members. The tool consists of five age appropriate risk assessments. Each assessment has accompanying education pieces to be used to educate members on various topics, for example: home safety nutrition, injury prevention, etc.

The IHA will help PCPs identify patients in need of health education, counseling, and other medical and social services. The PCP is responsible for the following:

• Assessing whether the member has had a complete physical exam in the last year. If the member has had a physical exam by another physician, the member should sign a medical records release to request the exam and incorporate into the member’s chart.
• Documenting all findings into the medical record.
• Performing the Staying Healthy Individual Health Education Behavioral Assessment. The goal of the assessment is to identify high risk behaviors of individual members, prioritize individual health education needs related to lifestyle, environment, and cultural linguistic background, and to initiate and document focused health education intervention referral and follow up (See Section 12 for age specific Assessment forms).
• Administering the appropriate Staying Healthy Individual Health Education Behavioral Assessment to all new members and to all existing members who present for a scheduled visit. The Assessment is age specific and must be administered at the next preventative health visit after the next age plateau is reached. A copy of the age specific assessment tool is provided to the PCPs by the health plans.

Unless deemed inappropriate by the physician, or refused by the member, health assessments should include:

• Health and developmental history
• Unclothed physical examination, including assessment of physical growth
• Assessment of nutritional status
• Inspection of ears, nose, mouth, throat, teeth and gums
• Vision screening
• Tuberculin testing and laboratory tests appropriate to age and sex, including test for anemia, diabetes, and urinary tract infections
• Blood lead testing
• Testing for sickle cell trait where appropriate
• Immunizations appropriate to age and health history necessary to make status current
• Anticipatory guidance and health education appropriate to age and health status, including harmful effects of the use of tobacco products and exposure to second hand smoke

Please Note: If the member refuses to give this information, this should be documented in the medical record.

3.10 Medical Records
The Primary Care Physician is responsible for maintaining a legible, detailed, confidentially stored, easily retrievable medical record for each patient for ten (10) years, as required and mandated by Centers for Medicare and Medicaid (CMS). The medical record of a patient is a confidential document used by the physician to maintain a systematic record of the patient's continuing medical care.

Release of medical information and records will be in accordance with Federal, State and local statutes. (Refer to the Forms Section for the Medical Record Release Form)

A. Confidentiality

Medical records will be stored in an area of the medical practice, with access limited to authorized staff only. All staff members must sign a Confidentiality Statement that assures that the access to medical records and the information therein is confidential, and that this information may not be released without permission, nor can it be sold in total or any part thereof.

All patient information is confidential and must be protected from disclosure to unauthorized personnel in accordance to the Federal HIPAA Act of 1996 regulations and applicable State laws. Patient information includes the patient’s name, address, telephone number, social security number or Medi Cal identification number.

B. Standard Requirements

The following requirements apply to ALL Medical Records:

• A separate medical record is maintained for each patient.
• The medical record is to be stored in a secured place.
• Each medical record will contain at a minimum:
  • Complete patient name
  • Date of birth
  • Gender
  • Marital Status
  • Home address and phone number
  • Employer address and phone number (if applicable)
  • Insurance and member identification number
  • Signature on file for consent to treatment
  • Member’s Primary Language indicated in writing
• All pages in the medical record must contain the patient name or identification number.
• All entries are dated and signed by the author. Full signature and title is required.
• All entries must be dated and signed or initialed by the Provider
The medical record must be legible to others besides the provider and their staff.

C. Notation Requirement

A notation must be made for each visit and must include:

- Date of the visit
- Chief complaint
- A documented physical exam relevant to the complaint
- Diagnosis / Impression
- Medication list includes medication history as well as current medications
- Medication allergies, adverse reactions, or the absence of known allergies are noted in a consistent fashion
- Problem list includes medical conditions and significant illnesses and surgeries
- A comprehensive health history is documented for patients seen three or more times. For children and adolescents under 18 years old, the history includes,
- Prenatal and perinatal care, childhood illnesses, and surgeries
- For patients, over 14 years old, use of tobacco, alcohol, and substance abuse are documented for patients seen more than three times
- Progress notes which must document:
  - Height, weight, vital signs
  - Chief complaint and unresolved problems from previous visits
  - Physical exam consistent with chief complaint
  - Working diagnosis
  - Tests, referrals, consult, and plan of treatment consistent with working diagnosis
  - Prescribed medications include name of drug, dosage, and administration frequency, and duration
  - Follow up plan and date of return visit or PRN
  - Health education and preventative care
- Telephone advice is documented
- The physician initials and dates consultant summaries, laboratory, and other diagnostic reports. Consultant summaries and abnormal lab and diagnostic test results have a chart entry including a follow up care plan
- Immunization records appropriate to age are initiated on all patients
- Preventive screening and health education services are offered
- Problems lists are updated with each visit and unresolved problems are addressed at the next visit.
- Missed appointments are to be documented in the medical record. At a minimum, three attempts will be made to determine the cause of the missed appointment.
- Documentation includes a notation of the time and method used to contact the member
- Refusal to have a translator outside of family and or friend must be documented
- Any access to care problems are to be documented in the medical record

3.11 Vaccine and Immunization Administration

Vaccines for Medicare Advantage HMO members shall be the sole responsibility of the PCP. Please refer to the PCP Agreement for reimbursement information.
SECTION 4. ENCOUNTER DATA AND CLAIMS SUBMISSION

4.1 Encounter Data Submission

Encounter data is used to report medical services for patients under capitated contracts. The encounter data is very similar to the information submitted on a fee for service form, but no service related reimbursement occurs. Encounter data must be submitted weekly and on a CMS 1500, when applicable, a PM160 INF or where applicable, UB92. Health Plans imposes significant financial penalties for lack, or inadequate submission, of Encounter data.

4.2 Claims Submission

Industry standards require that all claims be submitted within 60 calendar days following the end of the month, and no later than 90 days, from when care was rendered. Claims will be processed and payments made in accordance with the Timeliness Guidelines as promulgated by the CMS Medicare Program. Claims should be submitted to IPA for those services that are performed by the physician that are not covered under capitation and/or according to the contract. The IPA will only accept claims submitted on an industry standard CMS 1500 or UB92 Claim Form.

In order for the IPA to accurately adjudicate claims and ensure timely processing and payment for services rendered to IPA members, it is imperative that all the required information on the CMS 1500 is provided. All claims submitted will be reviewed to ensure that the billed level of care is consistent with level of care authorized by IPA and/or service level of care provided by provider with proper documentations. In the event a higher level of care is billed, IHHMG will pay based on authorized level of care.

For a complete submission, the following minimum information must be on all CMS 1500 claims to be considered a “clean claim” or encounter data submissions*, otherwise the claim may be pending or denied:

- Patient's name and date of birth*
- Patient's Insurance identification number*
- Patient's complete address*
- Date of onset of illness or injury or Last Menstrual Period (where applicable)*
- ICD 9 Code and Diagnosis and Procedure and modifier code(s) (CPT or HCPCS)* - ALL PERTINENT ICD-9 AND CPT CODES PERFORMED DURING EACH VISIT
- Referring physician
- Date of service, place of service, type of service, quantity/unit of service(s), and normal charges*)*
- Authorization Number in Box 23 of CMS-HCFA 1500 Form (when required)
- The Physician's Federal Tax ID number, Medi-Cal or Medicare Provider number, UPIN number (where applicable)*
- Name and address of facility where services were rendered
- Name, address, zip code and phone number of Physician submitter*
- Attached OR or ER notes and Medical Reports for E&M codes billed as complex or severe
- A copy of the authorized referral attached to the claim
- EOMB or EOB attached if other coverage (COB) applies

For all billable services/claims, they must be submitted on the respective CMS 1500 or UB-92 form for services rendered. Superbills are not acceptable as claims for reimbursable services (i.e., non-capitated services, etc.) Send ALL claims to the following address:
Please refer to the Compensation Fee Schedule of your Provider Agreement to determine the payment amount the provider may be expected to receive for his/her service(s)s rendered. All payable claims shall be processed in accordance to the fee schedule and guidelines promulgated by each government program. Medicare Advantage HMO claims shall adhere to the prevailing Medicare Fee Schedule and Claims Processing and Payment Guidelines as established by CMS.

For ENCOUNTER DATA submissions, they must be submitted on either LEGIBLE superbills with complete information, or on a CMS (HCFA) 1500 Form. Send ALL encounter date to the following address:

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP
ENCOUNTER DATA DEPARTMENT
600 South Lake Ave Suite 308
Pasadena, CA  91106

IHHMG prefers that providers submit encounter data electronically. The management company will provide training on electronic authorization and encounter data entry upon orientation.

Special services that cannot be identified with the appropriate CPT or HCPCS codes shall undergo IPA medical review and, if allowable, will be processed at industry standard norms.

For the Medicare Fee Schedule, providers may access the internet website at:

http://www.cms.gov/Medicare/Medicare.html

(Refer to Section 10.3 for information regarding claim disputes)
SECTION 5. ENROLLMENT AND ELIGIBILITY

5.1 Eligibility Verification
Patient eligibility must be verified before providing any service. Possession of a membership card DOES NOT guarantee eligibility.

- Providers are encouraged to check eligibility of Medicare members by calling IHHMG or the Health Plan directly.
- Always try to find the member's name on the most recent IPA Eligibility List (E List). The E List will be mailed to your office on a monthly basis.

Reminder: Balance billing of any HMO member who is eligible at the time of service is expressly prohibited by state regulations, the HMOs, as well as the IPA.

5.2 Eligibility List (Refer to the Eligibility Verification Form)
The Eligibility list provides monthly information on member enrollment for each Health Plan for every product line (i.e. Medicare Advantage, Medi Cal and/or Healthy Families).

5.3 Capitation Report
The Capitation Report provides monthly information on capitation payment for each member. Capitation is mailed out to providers approximately 10 working days from receipt of capitation payment from the contracted health plan.

5.4 Member Disenrollment
For Medicare Advantage members, the member is locked into the Plan of choice for a period of 12 months, after open enrollment occurs.

Medicare Advantage Medi-Medi members, have the option to change Plans on a month to month basis. PCPs are encouraged to maintain members to promote continuity of care.

5.5 Provider Status Change (Refer to Provider Status Change Form)
Any planned change in status such as an address or phone number change, malpractice insurance coverage or staffing changes, must be reported immediately, and at least ninety (90) days prior to the change, to the Credentialing Department at IHHMG.
SECTION 6. REFERRALS

6.1 Referral Authorization Process and Guideline
PCPs are responsible for obtaining an authorization when referring a patient for specialty services. (Refer to the Forms Section for Referral Authorization Forms).

Specific Specialty physician services are covered only if they are properly authorized. The authorization requests should be initiated by the Primary Care Provider for the initial referral, or by the specialist for follow-up services with the same specialist. If the patient requires a specialist to specialist referral (for example: an orthopedist wants to refer a patient to a neurologist), the patient must be referred back to the Primary Care Physician. PCPs should use a Specialist Provider within Imperial Health Holdings Medical Group panel. Fax authorization request forms to:

Imperial Health Holdings Medical Group
Attn: Utilization Management Department
Phone No.: (626) 838-5100 Ext 1
Fax No.: (626) 364-0329

In accordance with National Committee on Quality Assurance (NCQA) standards, UM staff at IHHMG and Medical Directors who make or supervise utilization related decisions base these decisions only on the clinical appropriateness of care and service.

Imperial Health Holdings Medical Group does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. In addition, there are no financial incentives for Utilization Management decision makers, and Imperial Health holding medical group does not encourage decisions that result in underutilization.

6.2 Sensitive Services [FOR MEDI-CAL MEMBERS ONLY]
Patients do not require an authorization for self-referring to a provider of their choice within the network for the following sensitive services:

- Family Planning
- Communicable Diseases, STDs
- HIV testing and counseling

Provider is responsible for referring patients to an IPA contracted specialist. All referrals for spine, pelvis, head and femur fractures for patients under 21 years of age will require authorization as these conditions may qualify for CCS coverage.

6.3 Approval Process for Routine Referrals
- For Medicare Advantage members, allow 14 calendar days for authorization of non emergent referrals.
- Use the IPA Referral Forms provided
- In order to avoid unnecessary delays, the following information must be provided:
  - Member's Name
  - Member ID Number
  - Specialist Name
  - Reason for referral (provide all pertinent progress notes which may include diagnostic test results, medications or treatments tried)
  - Number of visits requested
• CPT and ICD9 codes
Fax authorization form to IPA Utilization Management Department at (626) 364-0329.

For guidelines on authorization turn-around time for each type of insurance/coverage, please refer to www.iceforhealth.org or contact the UM Department.

6.4 Approved Referrals
Once a referral request is approved, the IPA Utilization Management Department will notify the PCP, the patient/member and the Specialist of the approval.

It remains the responsibility of the PCP’s office to notify the patient once the referral has been approved. Please make sure that the name, address, and phone number of the specialist are given to the patient.

It is the responsibility of the PCP to track and record the member having kept the appointment with the specialist, date and time.

6.5 Denied Referrals
IPA’s UM department will mail a letter to the patient and the provider informing them of any denial. The letter contains information on the Appeal Process.

A copy of the Denial Letter is sent to the PCP. Attached to the letter is the medical policy criterion for the denial. This letter should be filed in the member's medical record.

The referral may be denied for one of the following reasons:
• Member is not eligible with IPA
• Service requested is not a covered benefit
• Service requested is the responsibility of the Primary Care Provider
• Medical necessity could not be established

Please Note: If the information provided on the referral form is not sufficient to determine medical necessity, a letter requesting additional information will be sent to the PCP. The missing information may be:
• Lab or other diagnostic test results
• Additional family or personal health history
• Consultation or progress notes from the PCP or Specialist

Utilization criteria and guidelines are available upon request, but only for the specific procedures or conditions requested.

6.6 Emergency Room Utilization, Urgent Care and Emergent Referrals
Emergent is defined as a sudden injury or onset of illness that, if immediate care is not provided, may result in permanent damage or cause loss of life or limb to patient.

The Primary Care Physician or his/her on call physician is responsible for determining the medical necessity of an Urgent Care or Emergency Room visit. After hours, Urgent Care Referrals should be directed to the contracted Urgent Care Centers (listed on Provider Rosters):

The Emergency Room MUST NOT be utilized in lieu of the Primary Care Physician's office. Only true medical emergencies should be referred to the Emergency Room.

• The Primary Care Physician is responsible for immediately responding to all calls from the emergency room.
• The patient will receive a medical screening exam (MSE) in the Emergency Room.
• The PCP should evaluate the situation and give the specific orders to the ER staff.
• If the patient can be treated and released with no further treatment, the patient should be released and instructed to follow up with the PCP, NOT THE EMERGENCY ROOM.
• If the patient requires additional treatment the PCP must be contacted.
• For an inpatient admission, the ER staff should obtain an authorization from the PCP. If PCP does not have admitting privileges at the hospital, the Admitting Physician should be called.

Procedure for Emergent Referrals

1. Make sure the Referral Form contains the following information: Member’s name, reason for referral, Member ID number, number of visits requested, specialist name, CPT and ICD9 codes
2. Fax a copy of the Authorization Referral Form to IPA UM Department at (626) 364-0329. Requests may also be phoned in.
3. The Utilization Management Department will review for eligibility, benefit coverage and medical necessity.
4. PCP and Specialist will receive a copy of the authorization by fax or electronically within 72 hours if the authorization is approved and within 48 hours if the authorization is denied or modified. Verbal authorizations may be given but need to be followed up in writing.

The Primary Care Physician is responsible for notifying IPA UM Department via fax at (626) 364-0329 or via phone at (626) 838-5100, of any emergency room visit or emergency inpatient admission by the following business day.

In the event the PCP is unaware of an inpatient admission; the UM department will notify the PCP as soon as the information comes forward.
SECTION 7. NON COVERED PROGRAM SERVICES

7.1 Non covered Medicare Advantage and/or Medicaid Services

The following services are not contractually covered and therefore should not be submitted for referral authorization:

• Services not received from or prescribed, referred, or authorized by IPA (except in the case of emergency or urgent care)
• Services not specifically included in the Evidence of Coverage and Disclosure (Member Handbook) provided by the Health Plan
• Services rendered prior to beginning date as a member of IPA or following termination of coverage
• Hospital or Medical services that are not medically necessary
• Cosmetic Surgery (Breast reconstruction is a covered benefit if following mastectomy or catastrophic disfiguring trauma)
• Experimental Services
• Infertility treatment (Refer to Plan Member’s EOC for limitations)
• Unauthorized ambulance transportation for a non emergency situation

In any case, any questions arising regarding covered benefits may be forwarded to the UM department for further investigation

7.2 Non-Covered Other Lines of Business Services

Check with each individual Plan Program’s Covered Benefits and Evidence of Coverage to determine if services are covered.
SECTION 8. LINKED AND CARVED OUT MEDICARE SERVICES

Below are some of the examples of services that are linked or carved out of the members Health Plan benefits, Medicare, or the Medi-Cal Programs. IPA and Plan will help coordinate these services with the provider and the appropriate public health agency.

For Medicare Advantage, Managed Care Program:

- Adult Day Health Care Services
- Custodial Care (Medi-Medi Managed Care shall defer to member's Medi-Cal Plan)
- Dental Services
- Optometry Benefits
- Prescription Drugs – Medicare Part D
SECTION 9. MEMBER HEALTH EDUCATION

9.1 Provision of Health Education Materials
All affiliated Health Care Providers are responsible for providing and/or arranging for Culturally and Linguistically appropriate health education, prevention and counseling services to Medicare managed care members, and to encourage members to take increased responsibility for their personal health. Imperial Health Holdings Medical Group can assist you with any brochures, documentation, or related information in many languages and for various health topics. Please contact our Cultural and Linguistics Representative through for more information on how to obtain materials. (See Section 2.1 Imperial Health Holdings Medical Group Phone Numbers)

9.2 Documentation of Health Education in Medical Records
Documentation of health education provided to managed care members in medical records should include:
- Date
- Health education relative to the diagnosis and/or presenting problem
- Any support materials given to or presented to the Patient (e.g., "patient viewed asthma video" or "patient given brochure on diabetes.")
- Patient's understanding of the education provided
- Any follow up needed or that is appropriate (e.g., completed referral form, attended class, re visit scheduled)
- Referral to health education services
- Signature and title of all staff providing health education
- Health education activity rendered (e.g., one on one consultation, class, support group session)
- Health education resources provided (e.g., brochure, newsletter, videotape, audiotape)

9.3 Health Education Topics
There are many resources that provide health education materials on the following topics that are mandated by the State Department of Health Services:
- Anticipatory Guidance
- Asthma
- Dental Health
- Diabetes
- Exercise
- HIV / STD
- Injury Prevention
- Lead Poisoning
- Nutrition*
- Substance Abuse
- Tobacco Prevention/Cessation
- Tuberculosis

IPA also has health education materials available. We will provide them for your Medicare or Medi Cal members upon request. (Please refer to the Health Education Referral Form in the Forms Section, Section 14 of this manual.)
9.4 Advance Directives

An Advance Directive is a formal document, written in advance of an incapacitating illness or injury in which one can assign decision making for future medical treatment. California legally recognizes the Durable Power of Attorney for Health Care (DPAHC) as Advance Directive for adults.

The responsibility of the PCP is as follows:

1. Provide all members 18 years old and above with the Patient Rights Brochure. A copy must be provided to the member at the initial encounter with their PCP.
2. Provide the member with the pamphlet, which addresses Advance Directives, surrogate decision making and the forgoing of life sustaining procedures.
3. The PCP may assist members who have questions about an Advance Directive; however, he/she may not influence the member in making the decision regarding the member’s health care.
4. Documentation in the medical record must be entered when the member has been informed of his/her right to execute an Advance Directive and/or whether the member has actually executed an Advance Directive.
5. When the member executes an Advance Directive, a signed copy must be in the medical record.
6. If the patient does not have a written Advance Directive but expresses his/her intentions regarding future medical care, the PCP shall clearly document all communications regarding the Advance Directive issue in the medical record. This information must be available to alternate decision-makers for the member in the event subsequently becomes incapable of directing his/her care.

For more information and forms please contact:

The California Medical Association
P.O. Box 7690
San Francisco, CA 94120 7690
(415) 882 5175

California Health Decisions
500 South Main St., Suite 400
Orange, CA 92668
(714) 647 4920

IPA will provide a copy of the Advanced Directive Form to the provider upon request.

9.5 CULTURAL & LINGUISTIC REQUIREMENTS AND SERVICES

The Health Education Department of the Health Plan where the patient is a member is responsible for providing and ensuring health education materials and services meet cultural and linguistic standards as well as material topic requirements. Materials and services are available to members in English and Spanish and some in other languages including Vietnamese.

Interpreter Services at Provider Site

- Providers are required to offer interpretive services to a member if necessary in order to provide quality services.
- Providers also must post a sign indicating the availability of interpreter services.
• Members are not required to use family members or friends as interpreters.
• Contracted providers should not require nor suggest the Limited English Proficient (LEP) members provide their own interpreters. The use of family, friends, and/or minors may compromise the reliability of medical information. Use of these people could also result in a breach of confidentiality or reluctance on the part of the beneficiaries to reveal personal information critical to their situations.
SECTION 10. COMPLAINTS AND GRIEVANCES

10.1 Member Complaints and Grievances

The complaint and grievance process applies when a member or provider files a complaint that does not involve a determination of coverage. Grievances may be filed for issues regarding quality of care, termination, adequacy of facilities, waiting times, or interpersonal problems with providers. Please keep the following in mind:

• Members must be informed of their right to complain and may submit complaints orally or in writing to the health plans
• Members may be directed to call the Health Plans’ Member Services Department to file a grievance.
• Members can obtain a complaint form, either from their provider's office, or the PHC (Refer to the Forms Section for a copy of the grievance form)
• IPA and/or Health Plan are required to acknowledge a member’s complaint within five (5) working days and resolve the member's complaint within thirty (30) working days.
• Members can call the Plan and/or the Department of Managed Health Care (DMHC), if the complaint is not resolved to their satisfaction.

Most common grievances result from:

• Length of time required to see the physician or schedule appointments
• Difficulty in obtaining referral
• Lack of courteous treatment on the part of physician's personnel
• Crowded or cluttered waiting room conditions
• Member feels that the physician is not giving the member what he/she wants versus the physician providing what is needed

10.2 Physician Complaints

Physicians and other health care providers are encouraged to aid in the overall quality improvement efforts of the provider network by bringing forth issues that affect member’s care, operational issues, or other service problems.

• Physicians and other health care providers with provider issues can submit a grievance to the IPA by telephone, fax or letter.
• Quality Management staff will assist in resolving the issue and will forward the complaint or problem to the health plans.
• Physicians will receive written confirmation of the outcome of the grievance investigation and the QM Committee's findings. Administrative and operational issues will be resolved within 5 business days. Providers will receive written confirmation of the outcome of the grievance.

10.3 Claims Settlement & Grievance Practices

Provisions under AB1455 provide for fast, fair, and cost effective dispute resolution mechanisms for claim disputes. A claim dispute/grievance will be processed under the IPA’s Provider (Claim) Dispute Resolution Policy & Procedure guidelines. Disputes must be submitted in a written format and clearly document and identify the issue at dispute. (Refer to the following “Downstream Provider Notice” for full disclosure and instructions.)
Claims grievances for Medicare Advantage Program are processed under CMS regulatory guidelines and shall adhere to the timelines for receipt and response as promulgated.

10.4 Member and Provider Satisfaction Surveys
In order to measure the overall satisfaction of individual physicians and members IHHMG requests that physicians participate in data collection regarding satisfaction.

Physician Satisfaction are recommended to be completed at least once a year.

Attached forms 13.9 and 13.10 are provided for the purpose of gaining information regarding satisfaction. Form 13.9 is Member Satisfaction form. The IPA asks that Primary Care Physicians give these to members to fill out. Members may fill the form out and return it to the PCP or, if needed, office staff can assist the member in completion.

Form 13.10 is Physician Satisfaction Form. This form is for the PCP to complete.

Both forms should be faxed back to the identified number at the bottom of the form.
SECTION 11. COMPLIANCE

11.1 Code of Conduct and Business Ethics

The Code of Business Conduct is a critical component of a compliance plan. Imperial Health Holdings Medical Group is committed to upholding the highest standards of integrity by following the Guiding Principles of Business Conduct, as follows:

- Be Fair and Responsive in Serving Our Customers
- Always Earn and Be Worthy of Our Customers’ Trust
- Respect Fellow Employees and Reinforce the Power of Teamwork
- Demonstrate a Commitment to Ethical and Legal Conduct
- Maintain Our Business and Compliance Standards
- Continuously Strive to Improve What We Do and How We Do It

11.2 Compliance Program

Imperial Health Holdings Medical Group’s Compliance Program has the potential of enhancing the quality, productivity and efficiency of our operations while significantly reducing the probability of improper conduct and legal liability, including but not limited to reducing fraud and abuse. Imperial Health Holdings Medical Group’s Compliance Program strives to improve operational quality by fulfilling four primary goals:

- Articulate and Demonstrate Imperial Health Holdings Medical Group’s Commitment to Regulatory Compliance and Legal and Ethical Conduct
- Increase the Likelihood of Preventing, Identifying and Correcting Non-Compliant or Illegal Conduct.
- Formulate and Utilize Internal Controls to Promote Compliance with State and Federal Laws and Regulations as well as Organizational Policies and Procedures.
- Create an Environment that Encourages Employees to Recognize and Resolve Potential Compliance Problems.

All providers, including provider employees and provider sub-contractors and their employees, are required to comply with Imperial Health Holdings Medical Group compliance program requirements. Imperial Health Holdings Medical Group’s compliance-related training requirements include Corporate Integrity, HIPAA Privacy and Security Training and Fraud, Waste and Abuse (FWA) Training.

11.3 Fraud, Waste and Abuse Compliance

The purpose of the Imperial Health Holdings Medical Group Fraud and Abuse Awareness and Detection Plan is to comply with Section 1348 of the California Health and Safety Code and other related state and federal laws, to identify and reduce costs to Imperial Health Holdings Medical Group, our providers, subscribers, payers, and enrollees caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. This goal includes activities that are detailed in the anti-fraud plan. This includes activities that:

- Protect California health care consumers and particularly Imperial Health Holdings Medical Group members, providers, and Imperial Health Holdings Medical Group itself against potential fraudulent activities;
- Prevent fraudulent activity through deterrence;
- Retrospective drug utilization review of controlled substances claims for possible fraud and/or abuse by specific indicators such as multiple prescriptions, multiple prescribers, etc.
- Detect fraud through existing mechanisms (such as claim fraud detection systems);
• Comply with the requirements of Section 1348 (a through e) of the Knox Keene Act;
• Provide a procedure for Imperial Health Holdings Medical Group staff to follow if fraud is suspected; and
• Notify the appropriate internal departments, company officers/Board of Directors and/or government agencies.

The Imperial Health Holdings Medical Group Fraud and Abuse Awareness and Detection Plan is made available for review in the Compliance Department and is reflected in the Fraud & Abuse Reporting System Policies and Procedures located on the Imperial Health Holdings Medical Group intranet. A hard copy of these policies and procedures is available to employees and other interested parties through the Imperial Health Holdings Medical Group Administrative Offices. Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) providers and their employees must complete an annual FWA training program.

Imperial Health Holdings Medical Group has established a Fraud and Abuse Compliance Hotline (hereinafter “Hotline”), which is available to all employees and Members 24 hours per day, 7 days per week. The Compliance Department has a system in place to receive, record, respond to and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees and FDRs and their employees.

Employees, members, or any other interested party may call the Hotline to report suspected fraudulent, illegal, or non-compliant behavior affecting Medicare, or any other product line, at Imperial Health Holdings Medical Group. Imperial Health Holdings Medical Group will make every effort to maintain the confidentiality of the report and the reporting employee or other individual, however, the identity of the employee may become known or may have to be revealed in the course of the investigation. The hotline telephone number is (800) 497-5509. Imperial Health Holdings Medical Group has also implemented a hotline email address, Compliance@imperialhealthholdings.com

Members, Imperial Health Holdings Medical Group employees, providers or any other person who feel they may have knowledge of something suspicious may use this hotline. This hotline will help our members, employees, providers, and purchasers feel secure that their services, money, and equipment are used appropriately. Only callers that leave their name and telephone number will receive a confirmation case number. However, if callers or those that email indicate that they wish to remain anonymous, they will not be contacted.

11.4 HIPAA Privacy practice notice guidelines
A. Background
Timely, accurate and complete health information must be collected, maintained and made available to members of an individual's healthcare team so that members of the team can accurately diagnose and care for that individual. Most consumers understand and have no objections to this use of their information.

Although consumers trust their caregivers to maintain the privacy of their health information, they are often skeptical about the security of their information when it is placed on computers or disclosed to others. Increasingly, consumers want to be informed about what information is collected, and to have some control over how their information is used.
B. Federal Requirements
Standards for Privacy of Individually Identifiable Health Information

In general, the federal Standards for Privacy of Individually Identifiable Health Information, also known as the HIPAA Privacy Rule (45 CFR Part 160-164) requires that:

Except for certain variations or exceptions for health plans and correctional facilities, an individual has a right to notice as to the uses and disclosures of protected health information that may be made by the covered entity, as well as the individual's rights, and the covered entity's legal duties with respect to protected health information.

In general, the content of the notice must contain:

1. A header "THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."
2. A description, including at least one example of the types of uses and disclosures that the covered entity is permitted to make for treatment, payment, and healthcare operations.
3. A description of each of the other purposes for which the covered entity is permitted or required to use or disclose protected health information without the individual's written consent or authorization.
4. A statement that other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization.
5. When applicable, separate statements that the covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual; raise funds for the covered entity, that the group health plan or health insurance issuer or HMO may disclose protected health information to the sponsor of the plan.
6. A statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights including:
   • the right to request restrictions on certain uses and disclosures as provided by 45 CFR 164.522(a), including a statement that the covered entity is not required to agree to a requested restriction
   • the right to receive confidential communications of protected health information as provided by 164.522(b), as applicable
   • the right to inspect and copy protected health information as provided by 164.524
   • the right to amend protected health information as provided in 164.526
   • the right to receive an accounting of disclosures as provided in 164.528
   • the right to obtain a paper copy of the notice upon request as provided in 164.520
7. A statement that the covered entity is required by law to maintain the privacy of protected health information and to provide individuals with a notice of its legal duties and privacy practices with respect to protected health information.
8. A statement that the covered entity is required to abide by the terms of the notice currently in effect.
9. A statement that the covered entity reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.
10. A statement describing how it will provide individuals with a revised notice.
11. A statement that individuals may complain to the covered entity and to the Secretary of Health and Human Services if they believe their privacy rights have been violated; a brief description as
to how one files a complaint with the covered entity; and a statement that the individual will not be retaliated against for filing a complaint.

12. The name or title, and telephone number of a person or office to contact for further information.

13. An effective date, which may not be earlier than the date on which the notice is printed or otherwise published.

Source: AHIMA Practice Brief, "Notice of Information Practices" (Updated 11/02)
SECTION 12. PROVIDER AND HOSPITAL ROSTER

12.1 Laboratory
American Bio-Clinical Laboratories (Please see Patient Service Centers Roster)
2730 North Main Street
Los Angeles, CA 90031
Tel: (323) 222-6688
Fax: (323) 222-3388
www.abclab.com

Quest Diagnostics (Please see Patient Service Centers Roster)
8401 Fallbrook Ave.
West Hills, CA 91304
866-MYQUEST (1-866-697-8378)
www.QuestDiagnostics.com

12.2 Radiology/Diagnostic Centers
UMI (United Medical Imaging Healthcare, Inc. - Please see area locations listing)
Arcadia Radiology Medical Group - Please see area locations listing)
Madison Radiology - Please see area locations listing)
RADNET/Beverly Radiology Medical Group - Please see area locations listing)

12.3 Contracted Hospital Facilities
IHHMG uses contracted hospital and inpatient facilities (skilled nursing, rehab, etc…) contracted with contracted health plans. The management company will periodically send the list of contracted hospital and facilities for each health plan to primary care providers. If the primary care provider has an immediate need to know the contracted hospital and facilities, please contact the UM department, look on the health plan’s website or contact IHHMGs provider services representative.

12.4 PCP and SPECIALISTS ROSTER
See Attached Roster
SECTION 13. FORMS
13.1 Adult Risk Assessment & Health History   Enclosed
13.2 Referral Authorization Request   Enclosed
13.3 Member Complaint/Grievance Form from Health Plan- Contact respective health plan
13.4 Health Education Referral Form
13.5 Community Resource Guide-Contact respective health plan
13.6 Facility Site Audit Tool   Contact respective health plan for pre-audit format (short form FSR available on www.iceforhealth.org)
13.7 Provider Satisfaction Survey   Enclosed
13.8 Member Satisfaction Survey (only available if disseminated by contracted health plans)
SECTION 14. MEDICARE ADVANTAGE PROGRAM/MEDICAL

Brand New Day HMO - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Please refer to the Brand New Day HMO’s website, http://brandnewdayhmo.com/

Easy Choice Health Plan (A Wellcare Company) - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Please refer to the Easy Choice Health Plan website, http://easychoicehealthplan.com/

Central Health Plan of California - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Please refer to the Central Health Plan website, http://centralhealthplan.com/

Care 1st Health Plan - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Care 1st Health Plan - Medical
• Summary of Benefits
Please refer to the Care 1st Health Plan website, https://www.care1st.com/

Alignment Health Plan - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Please refer to the Alignment Health Plan website, http://alignmenthealthplan.com/

Humana Health Plan - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Please refer to the Humana Health Plan website, https://www.humana.com/

Blue Cross - Medical
• Summary of Benefits
Please refer to the Blue Cross website, http://www.bluecrossca.com

Chinese Community Health Plan - Medicare Advantage Plan
• Summary of Benefits
• Prescription Drugs – Part D Q&A
Please refer to the Chinese Community Health Plan website, https://www.cchphealthplan.com/
SECTION 15. AB1455 CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

IMPERIAL HEALTH HOLDINGS MEDICAL GROUP DOWNSTREAM PROVIDER NOTICE

AB1455 CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products and other applicable lines of business where IMPERIAL HEALTH HOLDINGS MEDICAL GROUP is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

15.1 Claim Submission Instructions

A. Sending Claims to IPA

Claims for services provided to members assigned to IPA must be sent to the following:

Via Mail: 600 S Lake Ave Suite 308
Pasadena, CA 91106

Via Physical Delivery: Not currently accepting

Via e-mail: Not currently accepting

Via Fax: (866) 720-1012 (Dispute only)

Via Clearinghouse: N/A

B. Calling IPA Regarding Claims

For claim filing requirements or status inquiries, you may contact IPA @ (626) 838-5100 Option 3

C. Claim Submission Requirements.

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by IPA:

Submission of a Clean Claim within industry standard timelines per line of business with claims not to exceed 90 calendar days;

Submission of information and documentation upon request by IPA subject to Title 28 CCR 1300.71(a)(10)

D. Claim Receipt Verification.

For verification of claim receipt by IPA, please Contact Claims @ (626) 838-5100 Option 3, or Via E-Mail at: claims@imperialhealthholdings.com

15.2 Claims Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute.

A contracted provider dispute is a provider’s written notice to IPA and/or the member’s applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially
similar multiple claims that are individually numbered) that has been denied, adjusted or contested, or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider’s name; provider’s identification number, provider’s contact information, and:

If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider’s position on such issue; and

If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider’s position on the dispute, and an enrollee’s written authorization for provider to represent said enrollees.

B. Sending a Contracted Provider Dispute to IPA

Contracted provider disputes submitted to IPA must include the information listed in Section II.A, above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of: Provider Relations and Manager of Utilization and Quality Management at:

Via Mail: 600 S Lake Ave Suite 308
Pasadena, CA 91106
Via Physical Delivery: Not currently accepted
Via e-mail: Not currently accepted
Via Fax: (866) 876-1520

Time Period for Submission of Provider Disputes regarding Claims

Contracted provider disputes must be received by IPA within 365 days from provider’s action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or

In the case of inaction, contracted provider disputes must be received by IPA within 365 days after the provider’s time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted provider disputes that do not include all required information as set forth above in Section 15.2.A may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to IPA within thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes. IPA will acknowledge receipt of all contracted provider disputes as follows:

• Electronic (computerized format not currently available) contracted provider disputes will be acknowledged by IPA within two (2) Working Days of the Date of Receipt by IPA.
• Paper contracted provider disputes will be acknowledged by IPA within fifteen (15) Working Days of the Date of Receipt by IPA.

Contacting IPA Regarding Contracted Provider Disputes.
All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to IPA at: (626) 838-5100

Instructions for Filing Substantially Similar Contracted Provider Disputes.
Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:
• Sort provider disputes by similar issue
• Provide cover sheet for each batch
• Number each cover sheet
• Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheet

Time Period for Resolution and Written Determination of Contracted Provider Dispute.
• IPA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments.
• If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, IPA will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

15.3 DISPUTE RESOLUTION PROCESS FOR NON-CONTRACTED PROVIDERS
Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider’s written notice to IPA challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider’s name, the provider’s identification number, contact information, and:

If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider’s position on the dispute, and an enrollee’s written authorization for provider to represent said enrollees.

15.4 Claims Overpayments

A. Notice of Overpayment of a Claim
If IPA determines that it has overpaid a claim, IPA will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which IPA believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

B. Contested Notice
If the provider contests IPA’s notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to IPA stating the basis upon which the provider believes that the claim was not overpaid. IPA will process the contested notice in accordance with IPA’s contracted provider dispute resolution process described in Section 15.2 above.

C. No Contest
If the provider does not contest IPA’s notice of overpayment of a claim, the provider must reimburse IPA within thirty (30) Working Days of the provider’s receipt of the notice of overpayment of a claim.

D. Offsets to Payments
IPA may only offset an uncontested notice of overpayment of a claim against provider’s current claim submission when; (i) the provider fails to reimburse IPA within the timeframe set forth in Section 15.4.C., above, and/or (ii) IPA’s contract with the provider specifically authorizes IPA to offset an uncontested notice of overpayment of a claim from the provider’s current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider’s current claim or claims pursuant to this section, IPA will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim(s).

15.5 Effective Date
Pursuant to the terms promulgated under AB1455, this notice will be deemed effective for implementation as of January 1, 2004.
SECTION 16.  OFFICE ALLY & ONLINE SERVICES

Web Portal, IPA Website Please visit our websites to verify eligibility, submit claims, authorization submission, and inquiry status information. Providers can also take advantage of our on-line service to download a copy of the primary care physician and specialist provider rosters. You can also search individually for a PCP, specialist, and ancillary provider.

Our on-line features:

- Authorization status inquiry
- Authorization submission
- Claims status
- Provider rosters; provider search inquiries
- Member eligibility verification

To setup an account with Imperial Health Holdings Medical Group web portal, contact us at phone at (626) 838-5100

Office Ally Providers are encouraged to setup an account to start submitting all claims through Office Ally. Imperial Health Holdings Medical Group has opted to partner with Office Ally for all claims submissions.

Please note our payer’s ID is: IHHMG

To setup an account with Office Ally please contact them directly at (866) 575-4120, or you can email them at Info@OfficeAlly.com
SECTION 17. PATIENT’S RIGHTS AND RESPONSIBILITIES
CALIFORNIA PATIENTS BILL OF RIGHTS (REGULATORY) Title 22, California Code of Regulations Section 72527

It is the Patient’s Rights to:

1. Exercise these rights without regards to sex or cultural, economic, educational or religious background or the source of payment for the patient’s care.

2. Considerate and respectful care.

3. Knowledge of the name of the physician who has primary responsibility for coordinating the patient’s care and the professional relationships of other physicians who see the patient.

4. Receive information from the patient’s physician about the patient, the course of treatment and the patient’s prospects for recovery in terms that the patient can understand.

5. Receive as much information about any proposed treatment/procedure the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include the procedure/treatment, the significant medical risks involved, alternate course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.

6. Participate actively in decisions regarding the patient’s medical care to the extent permitted by law; this includes the right to refuse treatment.

7. Full consideration of privacy concerning his/her medical program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

8. Confidential treatment of all communications and records pertaining to his/her care. Patient’s written permission shall be obtained before medical records can be made available to anyone not directly concerned with his/her care.

9. Receive timely response to requests for services, including evaluations and referrals.

10. Leave the facility even against the advice of the patient’s physician.

11. Continuity of care, advance notice of time and location of appointment and physician providing medical care.

12. Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment and the right to refuse to participate in such research projects.

13. Be informed by his/her physician or a delegate of his/her physician of his continuing health care requirements following the patient’s discharge from the facility.

14. Examine and receive an explanation of the patient’s bill regardless of source of payment.

15. Have all patients’ rights apply to the person legally responsibility to make decisions regarding medical care.

16. Acquire information you desire about your Health Plan, including a clear explanation of benefits and services and how to receive them.
17. Obtain medically necessary health services, including preventive care.

18. Voice a complaint about a health plan or the care you receive through your plan’s grievance and appeal procedures, and to receive a timely response to any complaints or inquiries regarding your benefits or care.

19. Discuss (and complete) an advance directive, living will or other health care directive with your health care provider.

20. Receive a second opinion when deemed necessary by the contracting medical group.

21. Receive emergency service when you, as a prudent layperson, believe that a life-threatening emergency occurred. Payment will not be withheld in such cases.

22. Receive urgently needed services when traveling outside of the service area.

23. Not be discouraged to enroll in, or be directed to enroll in, any particular Medicare Choice plans.

**It is the Patient’s Responsibility to:**

1. Follow the plans and instruction for care agreed upon with his/her practitioners.

2. Provide, to the extent possible, information that the medical group and its practitioners and providers need in order to care for the patient.

3. Contact his/her physician or health plan with any questions or concerns about health benefits or health care services.

4. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.
Imperial Health Holdings Medical Group
Member Satisfaction Survey

1. How long did you wait to get an appointment
   To see your primary care doctor □ within 1 wk □1-2 wks □ 3 weeks □4 or more wks
   To see a Specialist □ within 1 wk □1-2 wks □ 3 weeks □4 or more wks

2. How long did you wait to see your physician once you have arrived at his/her office (past your appointment time?) □ 0-30 Min □ 30-60 min □ More than an hour

3. Was the front office staff courteous to you? □ Yes □ No

4. Was the back office staff courteous to you? □ Yes □ No

5. Was your physician courteous to you? □ Yes □ No

6. What is your overall satisfaction with the care and service provided through your physician and his/her medical group? □ Very satisfied □ Satisfied □ Dissatisfied

7. Would you recommend your physician to family and friends? □ Yes □ No

8. How long did you wait to get an answer on your referrals from Imperial Health IPA? □ 1-3 Days □ 4-5 days □ More than 5 days □ Not applicable

9. How satisfied were you with the services provided by your specialist: □ Very satisfied □ Satisfied □ Dissatisfied □ Not applicable

10. How satisfied were you with the case management program (services) provided: □ Very satisfied □ Satisfied □ Dissatisfied □ Not applicable

11. Did your provider help you regarding your treatment? □ Yes □ No

12. How long did you wait to resolve your grievance? □ within 1 wk □1-2 wks □ 3 weeks □4 or more wks □ Not applicable

13. How long did you wait to get your claims paid? □ within 1 wk □1-2 wks □ 3 weeks □4 or more wks □ Not applicable

14. Did your provider explain to you about your rights and responsibilities as a member of AHC IPA? □ Yes □ No

15. Did your provider give health education materials/referral for your health concern? □ Yes □ No

16. Did your provider give you Cultural & Linguistic information/referral for your health concern? □ Yes □ No

17. Did your provider give you free interpreter information/referral for your health concern? □ Yes □ No

Additional comments: ______________________________________________________________

Your primary care physician's name: ________________________________

Please return survey to: Imperial Health Holdings Medical Group 600 South Lake Ave Suite 308
Pasadena, CA 91106
2017 PROVIDER SATISFACTION SURVEY

Please take a few minutes to fill out this survey on the timeliness and quality of the service you receive from Imperial Health Holdings Medical Group and FAX it back to 626-205-9537. Thank you for your participation.

ADMINISTRATIVE SECTION

Provider Relations

1. I have been supplied with:
   A Provider orientation YES □ NO □
   Access to the Web Portal YES □ NO □

2. My Provider Relations Representative is knowledgeable and able to answer my questions
   Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

3. My Provider Relations Representative responds to my needs or concerns in a timely manner
   Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

Claims

4. My claims are processed in a timely manner
   Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

Claims inquiries are answered promptly

5. Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

6. Are you aware IHHMG accepts electronic claims submission through Office Ally?
   YES □ NO □

Capitation

7. My capitation payments are processed in a timely manner.
   Strongly Agree □ Agree □ Disagree □ Strongly Disagree □
8. My capitation payments I receive from IHHMG are accurate

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

9. Are my capitation payments paid according to contract rate?

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

Utilization Management

10. UM Representatives are helpful

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

11. Referrals are processed in a timely manner

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

12. Denial notifications consistently provided denial reasons

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

Credentialing

13. The Credentialing process occurred in a timely manner

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

14. Did I receive appropriate notice on need to Re-credential?

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

15. Credentialing Coordinator is courteous and knowledgeable

Strongly Agree □  Agree □  Disagree □  Strongly Disagree □

Please provide additional comments or suggestions:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.
<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Number</td>
<td>(626) 838-5100</td>
</tr>
<tr>
<td>Main Fax</td>
<td>(626) 521-6028</td>
</tr>
<tr>
<td>Eligibility</td>
<td>(626) 838-5100 Option 2</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>(626) 838-5100 Option 1</td>
</tr>
<tr>
<td>Utilization Management Fax</td>
<td>(626) 364-0329</td>
</tr>
<tr>
<td>After Hours Nurse Line</td>
<td>(626) 838-5100</td>
</tr>
<tr>
<td>Claims Department</td>
<td>(626) 838-5100 Option 3</td>
</tr>
<tr>
<td>Claims Forwarding Address</td>
<td>P.O. Box 60075 Pasadena, CA 91106</td>
</tr>
<tr>
<td>Claims Payer ID (Electronic Submission)</td>
<td>Office Ally: IHHMG</td>
</tr>
<tr>
<td>Contracting/Provider Services</td>
<td>(626) 838-5112 or (626) 838-5156</td>
</tr>
<tr>
<td>Contracting/Provider Service Fax</td>
<td>(626) 205-9536</td>
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